AFFIDAVIT OF PHYSICIAN PER SECTION 28-33-8(c) OF THE RHODE ISLAND WORKERS' COMPENSATION ACT

State of Rhode Island
Workers' Compensation Court
Medical Advisory Board
One Dorrance Plaza, Providence, RI 02903
Phone: 401-458-3460
TDD: 401-458-5275

EMPLOYEE INFORMATION:

Social Security No.: _____
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Date of Birth: _____

EMPLOYER INFORMATION:

FEIN: _____
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

IF THE IDENTITY OF THE INSURER IS UNKNOWN, CONTACT THE DIVISION OF WORKERS' COMPENSATION AT (401) 462-8116 FOR THE INFORMATION.

INSURANCE CARRIER:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

ADJUSTING COMPANY:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

EMPLOYEE'S INJURY INFORMATION:
Injury Date: _____ Incapacity Date: _____

PREPARED FOR THE WEEK AFTER EMPLOYEE'S DATE OF INJURY INDICATED BELOW
Six ○ Twelve ○ Eighteen ○ Other ○

SECTION 28-33-8(b) OF THE RHODE ISLAND WORKERS' COMPENSATION ACT PROVIDES FOR A $20.00 FEE TO BE CHARGED FOR THE TIMELY FILING OF THIS FORM WITHIN ONE WEEK OF THE DUE DATE.

Now comes the undersigned Physician and after first being duly sworn on oath makes affidavit and states:

1. The nature of the injury for which this employee is being treated is as follows:

Diagnosis: _____ ICD 9 Code: _____

Diagnosis: _____ ICD 9 Code: _____

Diagnosis: _____ ICD 9 Code: _____

2. The type of treatment provided to date, including frequency, is as follows:
Diagnostic Tests Performed: _____

Medication Prescribed: _____

Referred for Rehab.: _____ Facility: _____

Surgery: _____

Other Treatment Provided: _____

3. Anticipated further treatment, including type, frequency, and duration of treatment(s) is as follows: (If none, so state.)
Diagnostic Tests: _____

Medication: _____

Referred for Rehab: _____ Facility: _____

Surgery: _____

Other Treatment Provided: _____

4. (a) Is it possible that this treatment may fall outside the Medical Advisory Board Protocols?
Yes or No _____
(b) If the answer is Yes, please substantiate in detail.

_____

5. The employee's anticipated date of discharge is as follows: (If the employee has already been discharged, so state.) _____

6. Can the employee return to his or her former position of employment? Yes or No _____

7. (a) If the employee cannot return to his or her former position of employment, is the employee capable of work other than his or her former position of employment: Yes or No. _____

(b) The employee's work restrictions/capabilities are as follows: (If none, so state.)_____

_____

8. (a) Has the employee reached maximum medical improvement? Yes or No _____ If and only if the employee has reached maximum medical improvement, set forth the employee's degree of functional impairment, if any, based upon the most recent edition of the *American Medical Association's Guide to Evaluation of Permanent Impairment* or comparable publications of the American Medical Association:

Specify: % of Whole Body _____ % of Body Part _____

Indicate Body Part _____

(b) If the employee has not reached maximum medical improvement, the time when the employee is expected to reach maximum medical improvement is as follows: # of weeks _____ or # of months _____

9. The within-named physician and/or the within-named treatment facility has an ownership interest in an ancillary facility(s) to which this employee has been referred for treatment of this injury which is described as follows:
(If none, so state.) _____

Physician's Signature _____ Lic. # _____ Date: _____

Physician's Name _____ Title _____

Phys. Asst. Sig. _____ Supervising Phys. Name _____

Name of Facility _____

Facility Address _____

Subscribed and sworn to before me by the above-named physician this _____ day of _____, 20___.

_____
Notary Public
My Commission Expires: _____

MAB01 – 8/05
ORIGINAL, SIGNED AND NOTARIZED – MEDICAL ADVISORY BOARD
COPY TO INSURER/SELF-INSURED EMPLOYER
COPY TO PHYSICIAN'S FILE
COPY TO EMPLOYEE AND HIS/HER ATTORNEY